School Year 2024-2025

Clear Lake School District
Epi-Pen Auto-Injector Administration Authorization Form

Student Name: _____ Allergen: _____

School: _____ DOB:_____ Grade:_____

- The medication will have the student's name, the name of the medication, directions for use, and an expiration date.
- Authorization forms will be updated annually.

The student has the skill, knowledge, and authorization to use the medication in the following manner:
____ Student may carry their Epi-pen and are responsible for letting a staff member with them know about their allergen and where their Epi-pen is located.
____ Student should not carry their personal Epi-pen; a staff member will carry the medication in the primary classroom. (Elementary only)
____ Student should not carry their personal Epi-pen; it will be kept in the office.

Drug name:	Dosage:	Route:	Special Instructions:
			911 to be called after administration

I hereby give permission for school personnel to administer the medication(s) listed on this sheet to my child according to the practitioner and/or my instructions. I authorize them to contact the practitioner with questions or concerns. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, from administering the medication.

Parent/Guardian Name: _____ Phone Number:_____

Signature: _____ Date:_____

Practitioner Information:

Practitioner Name: _____ Clinic: _____

Practitioner Signature:_____Date: _____ Phone: _____

School Nurse Authorization: _____ Date: _____